

National Provider Identifier (NPI)

Seminar Registration

(No Fee)

Provider Name_____

Medicaid Provider Number_____NPI Number_____

Mailing Address_____

City, Zip Code_____County_____

Contact Person_____E-mail_____

Telephone Number(____)_____Fax Number_____

1 or **2** person(s) will attend the seminar at _____ on _____
(circle one) (location) (date)

For Raleigh location ONLY: **9:30-11:30 “Closed”** **1:30-3:30**_____

Please fax completed form to: 919-851-4014

Please mail completed form to:

EDS Provider Services

P.O. Box 300009

Raleigh, NC 27622